Medi-Cal Health Care Program Update

"To Enrich Lives Through Effective and Caring Service"

January 2008

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10-Day Processing of Newborn Referrals

This is to remind Eligibility Workers (EWs) of the policy for processing the Newborn Referral, MC 330, submitted by the infant's mother or by doctors, hospitals, other medical practitioners and individuals acting on the mother's behalf. The MC 330 and the procedures for its use were developed by the California Department of Health Care Services (DHCS) to expedite Medi-Cal enrollment of newborn infants. The infant must be added to the mother's existing case within the 10-day processing standard set by DHCS. **The 10-day period starts from the stamp or fax date on the MC 330.**

The Newborn Referral packet includes the Newborn Referral Transmittal (PA 6008), MC 330, LEADER and MEDS printouts. Within 10 days from the stamp or fax date on the MC 330 sent by the Medi-Cal Mail-In Application District #89, EWs must take action to add the newborn to the mother's case in LEADER. When adding the newborn to LEADER, EWs must ensure that the correct Client Identification Number (CIN), Person ID number and aid code are used. After adding the newborn to LEADER, EWs must check MEDS within three days to ensure that the newborn is receiving benefits with the correct aid code. District Administrators are to make certain that processing for Newborn Referrals is being monitored to ensure compliance with State regulations.

Reference: Administrative Bulletin #2311, dated 03-23-06
Administrative Directive #4201 Supp. I, dated 04/20/05
Administrative Directive #4201 Advance, dated 02/04/03
Administrative Memorandum #MPD 05-10, dated 05/16/05
ACWDL No. 03-49, dated 10/06/03

IMPORTANT REMINDER ABOUT DISABILITY REFERRALS!

A disability referral must be submitted to State Programs-Disability Determination Service Division (SP-DDSD) any time an applicant/beneficiary informs the county that he/she has a disability. This is applicable whether the person with the disability is a child or an adult, or whether or not the person is currently receiving Medi-Cal benefits under a different linkage. Make sure to complete the *Disability/DAPD* screen in LEADER, which is accessed through the Data Collection Subsystem. Once the evaluation is processed and the final disability decision is received, the *Results Tab,* must be updated to document the disability outcome.

When the person claiming disability is found to be disabled, the case is reevaluated to see if it is more advantageous for the household to receive benefits through the appropriate Aged/Blind/Disabled (ABD) program, with the exception of a household currently receiving benefits under 1931(b). Medi-Cal benefits for this household must continue under this program since 1931(b) is a federal mandated program that takes precedence over other Medi-Cal programs. In the instance that the household is no longer eligible for 1931(b), the case should be evaluated under the appropriate ABD Program.

Reference: Administrative Directive 4197 Advance, dated 10/10/02.

Hospital Letter and Identification Verification

This is a reminder to all staff that a letter from a hospital/institution verifying a beneficiary's Identification is an acceptable form of verification. Institution staff attempt to verify identity and in the absence of any other type of verification, will use the letter as a last resort. This form of verification applies only to cases that originate from an institution such as, but not limited to, a hospital or long-term care facility.

NOTE: In the absence of all other documentation, the signature on the Statement of Facts shall be accepted as verification of the beneficiary's identity.

Reference: CCR 50167 (a) (6); ACWDL 97-20, dated 05/15/97; ACWDL 00-31E, dated 06/23/00; Administrative Directive 4061, dated 02/08/01.

BCCTP Question

Scenario: Mother receiving Medi-Cal for self and daughter. Mother is currently receiving treatment for breast cancer and will be losing her Medi-Cal benefits due to her youngest child turning 21 years of age that same month. What steps need to be taken?

Answer: Once the case carrying worker is notified that this individual is still in need of treatment, the EW must initiate a DDSD packet, place the mother in aid code 6J and terminate the daughter's Medi-Cal eligibility at the end of that month.

Reference: ACWDL 06-25, dated 08/24/06
AD 4671, dated 08/28/07

Emergency Benefit Issuance Card (BIC) Issuances

This is a reminder to staff that beneficiaries should not be provided with a copy of the MOPI screen as an emergency Benefit Issuance Card (BIC). A new screen (SCRN) has been added to MEDS to replace the MOPI screen. Eligibility Workers shall complete the PA 5301 for the purpose of issuing an emergency BIC in the office.

- Eligibility Workers shall use ELIG instead of LOGS in the "CARD ISSUE SITE" field of the PA 5301 and SCRN instead of MOPI. LOGS and MOPI will no longer be used. The example below will issue an emergency card in the office:

CARD ISSUE SITE	E	L	I	G

CARD ISSUE SITE	S	C	R	N

- Eligibility Workers shall write the Client Identification Number (CIN) in the upper right hand corner of the PA 5301 as illustrated below. The CIN is mandatory for this form. If the CIN is not provided, a paper BIC cannot be printed.

PA 5301 **CIN# 9456224A**

Report MEDS Immediate Need Eligibility
Replacement Benefits Identification Card

Staff shall no longer issue BICs through LEADER.

Reference: MEDS Memo #89, dated 12-04-2006, MEDS Alert 2005 Training Questions and Answers.

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If one of your New Year's resolutions is NOT to miss one more issue of the Medi-Cal Program newsletter, good news! You can get past and current issues of the newsletter by logging on to the DPSS Website and clicking on the Health Care page. From there, look for the "Medi-Cal Monthly Updates" link. You will also see the Index and Table of Contents which makes it easy to find articles published in past issues of the newsletter.